

INSTRUCTIONS FOR UNIFORM BILLING DOCUMENT (Short Form) Not Respite

1. **PROVIDER NAME:** Provider name as contracted with ADES/DDD.
2. **FEI / SSN:** Provider's Federal Employer Identification # or Social Security Number
3. **PROVIDER OF SERVICE AHCCCS ID:** For Group Billers, enter the direct service provider's AHCCCS ID.
4. **MONTH/YEAR OF SERVICE:** The month and year that is being billed. One month per billing document.
5. **SERVICE:** The service that is being billed. One service per billing document.
6. **CONTRACT NUMBER:** The Provider's contract number. The contract number must correspond to the fiscal year that bills are submitted.
7. **DISTRICT:** Circle the appropriate District to be billed for this service.
8. **PROV LOC:** Two letter providers **Location Site Code** where service was delivered. (e.g. AA, AB, etc.)
9. **ASSISTS CONSUMER ID:** This is the ASSISTS consumer identification number assigned by the ADES/DDD.
10. **CONSUMER NAME/LAST:** The consumer's last name.
11. **CONSUMER NAME/FIRST:** The consumer's first name.
12. **SVC START DATE:** First day service was delivered (MM/DD/YY)
13. **SVC END DATE:** Last day service was delivered (MM/DD/YY).
(If there is a break in consecutive days of service, you need to use a new line)
14. **SVC CODE:** The three-character code that designates the service authorized and delivered. NOTE: Please use only one service code per page.
15. **P.O.S:** Place of Service code, enter the two digit code that indicates the **type of setting** where the service was delivered.

TWO DIGIT CODE	TYPE OF SETTING
11	Office
12	Patient's Residence (home, ADH, CDH, group home, IDLA, etc)
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
54	Intermediate Care Facility/Mentally Retarded
56	Psychiatric Residential Treatment Center
99	Other Unlisted Facility (e.g. park, transportation, store, etc)

16. **DELIVERED UNITS:** Enter the number of units delivered.
17. **NO SHOW/ABSENT UNITS:** Enter the number of absent units (RSA services only) or no show units (therapy treatments only). (Absent or No Show units billed for services other than RSA or therapy treatments will be cause to reject bill.) Indicate billable no show as NS; and billable absent as A otherwise leave blank.
18. **TOTAL UNITS:** Enter the total number of units. This is the total of number 16 and number 17.

19. **RATE:** Enter the contracted rate per unit/hour for the service.
20. **TPL CODE:** Third Party Liability Code, do not fill in. The ADES/DDD representative will complete. NOTE: For all consumers having insurance, please include an Explanation of Benefits (EOB) that corresponds to the service and date delivered or a waiver.
21. **TPL AMT:** Third Party Liability Amount, do not fill in. The ADES/DDD representative will complete.
22. **TOTAL (ROW):** Enter the total dollar amount billed (billed units/hours x rate = total amount).
23. **SITE RATE COUNT:** Enter the number of individuals sharing the service at common site, and common time. (i.e. RSP 3 persons multiple consumer. rate for each would be 3. Group home will be number of individuals sharing the day. If absent, still include in number. If vacant, don't include in number.)
24. **BUDGET SOURCE CODE:** ADES/DDD use only. The ADES/DDD representative will complete.
25. **TOTAL (COLUMN):** Located in the bottom right corner. Enter the total dollar amount of this column for this page only.
26. **CERTIFICATION STATEMENT:** The Preparer and the Provider must certify to the correctness of the invoice by providing signature, date and telephone number.
27. **TOTAL BILLING AMOUNT SUBMITTED UNDER THIS INVOICE:** Enter the total amount of all pages.